

VBH-PA HEALTHCHOICES PROGRAM

**PSYCHOLOGICAL EVALUATION REQUEST (PER) FORM
FOR PRE-AUTHORIZATION OF NEUROPSYCHOLOGICAL OR PSYCHOLOGICAL TESTING**

Psychological testing is encouraged where it is clearly indicated and necessary for diagnostic or treatment planning purposes. Requests for testing will only be considered when normal clinical evaluation fails to resolve questions that directly impact on the choice of treatment modalities for covered conditions. This report must be received and certified by VBH-PA prior to testing. Return to:

Value Behavioral Health of PA
520 Pleasant Valley Road
Trafford, PA 15085
Fax: (724) 744-6320

NOTE: Incomplete forms will be returned.

SECTION A – PATIENT INFORMATION

PATIENT'S NAME		
PATIENT'S MA ID#		
DATE OF BIRTH		

SECTION B – PSYCHOLOGIST/PROVIDER INFORMATION

NAME OF PSYCHOLOGIST/PROVIDER PERFORMING TESTING		
ADDRESS		
CITY	STATE	ZIP
TELEPHONE NUMBER	PA LICENSE NUMBER	

SECTION C – CLINICAL REFERRAL INFORMATION

(i) Who initiated this referral?
(ii) Describe current mental health symptoms and current level of functioning.
(iii) Is patient currently receiving mental health treatment? (i.e. outpatient, partial hospitalization, BHRS, family-based mental health). Please explain

(iv) Has patient ever received psychological testing? Yes No

Date if known:

Instruments used, if known:

Testing results, if known:

(v) Describe how proposed testing will clarify diagnosis and/or enhance future mental health treatment.

SECTION D – RELEVANT CLINICAL HISTORY

Describe mental health and substance abuse history of patient. Please include any previous psychiatric or substance abuse inpatient admissions or treatment.

SECTION E – RELEVANT MEDICAL HISTORY

Describe any medical conditions that may be affecting current behaviors/symptoms (i.e. thyroid dysfunction, traumatic brain injury, etc.).

SECTION F – LIST ANY CURRENT MEDICATIONS

MEDICATION	DOSE	FREQUENCY

SECTION G – CURRENT DSM IV DIAGNOSIS

AXIS I (please indicate both name and code):

AXIS II:

AXIS III:

AXIS IV:

AXIS V:

SECTION H – TESTING REQUESTED

List test(s) planned and time required. (NOTE: Time required for each test should include administration, scoring, interpretation, and write up.)

Specific Test(s) Planned	Hours
TOTAL	

Signature of Psychologist

Date

For Office Use Only

This request for psychological testing has been:

- APPROVED Total Hours _____
The tests approved above are the only tests which are being authorized after the initial test results are evaluated, further testing may be indicated. If so, the provider should contact VBH's Reviewer by telephone to discuss possible selection of specialized tests.
- DENIED
A Peer Advisor reviews all requests which are questioned by the Reviewer and must concur prior to denial.

PEER ADVISOR SIGNATURE

DATE